Department of Veterans Affairs **VHA DIRECTIVE 2000-034**
Veterans Health Administration
Washington, DC 20420 **October 2, 2000**

VHA MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)

1. PURPOSE: This Veterans Health Administration (VHA) Directive describes a new initiative in mental health intensive case management (MHICM) for seriously mentally ill veterans. ***NOTE:*** *This initiative takes the place of existing Intensive Psychiatric Community Care (IPCC) programs, Intensive Community Case Management (ICCM) programs, as well as other similar assertive community treatment (ACT) programs within VHA.*

2. BACKGROUND

a. Severe mental illness, primarily psychoses, is a major problem among veterans. Fiscal Year (FY) 1998 Compensation and Pension (C&P) data indicate that 136,362 veterans are service-connected for psychoses of which over 67,700 use VHA services. Over 174,030 veterans with psychoses, overall, used VHA services in FY 1998. The clinical literature suggests that approximately 20 percent of severely mentally ill patients are in need of intensive community case management services in the typical public mental health system. This intensive multidisciplinary team approach to ambulatory management and treatment of patients in, and coordinated with the community and its services, is clearly distinguished from usual case management by: engagement in community settings of highly dysfunctional patients traditionally managed in hospitals; an unusually high staff to patient ratio; multiple visits per week if needed; interventions primarily in the community rather than in office settings; and fixed team responsibility, around the clock, for total patient care over a prolonged period (see subpar. 2e(2)). Multiple studies, including three recent VHA studies, have shown that the intervention is cost effective, particularly where the service is offered to chronically ill, hospitalized patients and where the model is rigorously adhered to with respect to assertiveness of the intervention and maintaining low caseloads (see sub par. 2d). There is compelling evidence for the effectiveness of ACT in patients with psychosis, but its use may also be considered in severe and persistent affective disorder, post-traumatic stress disorder (PTSD), etc., where independent functioning is impaired. A FY 1998 survey by the Committee on Care of Severely Chronically Mentally Ill (SCMI) Veterans revealed that just over 8,000 veterans currently received some form of mental health team case management from VHA, and of those, only 2,000 met ACT Fidelity Measures criteria for intensive case management. Therefore, a gap in these state-of-the-art services is evident, resulting in unnecessary costs and patient morbidity to VHA.

b. On March 25, 1999, in order to obtain a wider range of views in formulating a VHA-wide approach, the Chief Network Officer appointed a SCMI Strategic Implementation Committee composed of four Clinical Managers, a medical center Director, a Mental Health Care Line Director, the National Director of the Northeast Program Evaluation Center (NEPEC), a representative of Vietnam Veterans Association, and a representative of the Mental Health Strategic Healthcare Group.

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c. The SCMI Strategic Implementation Committee considered various models of intensive case management within the Mental Health service area, then defined intensive case management for the severely mentally ill in VHA and the accountability expected from this designated program.

d. MHICM is a cost effective intervention given appropriate case selection. This may seem like a paradox given the known resource intensity of the interventions. The efficiency (offset) results from avoidance of other costly interventions such as multiple or lengthy hospitalizations, and extensive ambulatory clinic use, including visits to emergency rooms. Paragraph 3 notes that these programs need to be established from existing funds. To realize the efficiency and accomplish this out of existent resources requires a shift of resources that previously supported the extensive inpatient and outpatient use to underwrite MHICM. It is acknowledged that there will be a need for expedited mental health resource shifts, as well as shifts from other programs that gain economies from implementation of MHICM, including bed closures, where justified, as this more effective alternative of MHICM is implemented.

e. **Definitions**

(1) **Target Population.** MHICM programs are intended to provide necessary treatment and support for veterans who meet all of the following five criteria:

(a) Diagnosis of Severe and Persistent Mental Illness. Diagnosis of severe and persistent mental illness includes, but is not limited to: schizophrenia, bipolar disorder, major affective disorder, or severe post-traumatic stress disorder;

(b) Severe Functional Impairment. Severe functional impairment is such that the veteran is neither currently capable of successful and stable self-maintenance in a community living situation nor able to participate in necessary treatments without intensive support;

(c) Inadequately Served. This means inadequately served by conventional clinic-based outpatient treatment or day treatment;

(d) High Hospital Use. High hospital use as evidenced by over 30 days of psychiatric hospital care during the previous year or three or more episodes of psychiatric hospitalization;

(e) Clinically Appropriate for MHICM Approach. Patients who are more appropriately managed clinically as inpatients need to remain in the inpatient setting; that is, the positive aspects of MHICM should not be used to justify moving patients who would be better served by inpatient care to this ambulatory care model.

(2) **Description of the Program.** MHICM programs are delivered by an integrated, multidisciplinary team and are based on the Substance Abuse Mental Health Services Administration (SAMHSA) ACT standards. There are four core treatment elements:

(a) Very Frequent Contacts between Care Givers and Patients. The treatment process would include two phases:

1. High intensity of care primarily through home and community visits, with low caseloads (seven to fifteen veterans per clinician), allowing rapid attention to crisis and development of community living skills to prevent crisis in this exceptionally vulnerable population.

2. Appropriate transition to lower intensity care. After 1 year of MHICM treatment, patients can be transferred to either standard care or to continuous treatment by the MHICM team at a lower level of intensity (e.g., with caseloads of up to 30 per clinician). Characteristics of the readiness for a lower level of care would include the following: patients are clinically stable, not abusing addictive substances, not relying on extensive inpatient or emergency services, capable of maintaining themselves in a community living situation, and independently participating in necessary treatments. ***NOTE:*** *NEPEC will monitor this transition through periodic clinical progress reports and will report both levels of intensity separately.*

(b) Flexibility and Community Orientation. Flexibility and community orientation with most services provided in community settings and involving integration with natural support systems whenever possible (e.g., family members, landlords, employer).

(c) Focus on Rehabilitation. Focus on rehabilitation through practical problem solving, crisis resolution, adaptive skill building, and transition to self-care and independent living where possible.

(d) Responsibility. Identification of the team as a "fixed point of clinical responsibility" providing continuity of care for each veteran, wherever the veteran happens to be, for a prolonged period. This is expected to initially be 1 year, but subsequently will be based on a periodic review of continuing need for intensive services.

(3) **Data Recording**

(a) Attachment A. Attachment A contains the definitions of the revised Decision Support System (DSS) Identifiers for the MHICM workload (546 and 552) as well as the new code for general (non-intensive) mental health case management (564).

(b) Attachment B. Attachment B provides Veterans Integrated Service Networks (VISNs) and Department of Veterans Affairs (VA) leadership with population-based data to help facilitate assessment of the need for MHICM teams in each VISN. These data include the number of:

1. Veterans who meet inpatient utilization criteria (30 days of psychiatric hospitalization or three admissions);

2. Outpatients who meet diagnostic criteria for schizophrenia, bipolar, or major affective disorder and had six or more mental health outpatient contacts in FY 1998;

3. Veterans in the Psychiatric Special Care category under the Veterans Equitable Resource Allocation (VERA) system, and

4. Psychiatric patients with lengths of stay over 1 year.

(c) After a period during which new teams will be added to the roster of MHICM teams participating in the national program, NEPEC will present a data summary for each VISN of the ratio of MHICM-treated patients to those potentially eligible as estimated by each of the indicators of population need identified in Appendix B. VISNs may use these data to identify potential service gaps.

3. POLICY: It is VHA policy to support the development of case management approaches sufficient to meet the need where appropriate. Where the need for intensive mental health case management is demonstrated, MHICM programs need to be established out of existing funds (see subpar. 2d). ***NOTE:*** *NEPEC, which has developed and evaluated this type of program for 10 years, is providing the leadership for training and monitoring of new and established teams.*

4. ACTION

a. **Facility Actions.** Facilities are to:

(1) Utilize national DSS identifiers to designate MHICM activity.

(2) Provide complete nationally-adopted monitoring information for MHICM in a timely manner.

(3) Maintain team fidelity to the operating principles as described in the program description (see subpar. 2e(2)) and adhere to evidence-based clinical procedures. Adequate resources are needed to provide a critical mass of staff to comprehensively address the needs of these exceptionally vulnerable patients, even in the face of staff turnover and other absences. ***NOTE:*** *At least four clinical Full-time Employee Equivalent (FTEE) are needed for each MHICM team. Additional team members may be required in circumstances where the team is isolated from a VA medical center that can provide 24-hour coverage and emergency services. At sites where there are insufficient patients to justify a full team, consideration is to be given to partnering with the community, e.g., existing ACT teams.*

b. **Monitoring and Training Actions.** Because MHICM is resource intensive and the participating veterans are vulnerable, the following monitoring procedures will be implemented under the leadership of NEPEC. ***NOTE:*** *Forms may be obtained by contacting NEPEC by e-mail at "Robert.Rosenheck@med.VA.gov" or telephone at (203) 937-3850.*

(1) **Standard Intake Data Form (IDF).** Standard IDF will be administered to all new admissions to MHICM. It will document adherence to the eligibility criteria listed above and record baseline data on clinical status, functional impairment, and satisfaction with services. The IDF takes about 30 to 45 minutes to complete per patient.

(2) **Follow-up Data Form (FDF).** Follow-up FDF must be administered 6 months and 1 year after program entry and annually thereafter. It consists of a subset of health status and community adjustment measures from IDF. The FDF takes about 25 to 30 minutes to complete per patient.

(3) **A Clinical Process Form (CPF).** A CPF will document delivery of MHICM service elements and will be completed by each client's primary case manager every 6 months after program entry. The CPF takes about 15 minutes to complete on each patient.

(4) **MHICM Check List and ACT Fidelity Measure.** The MHICM Check List and ACT Fidelity Measure is to be completed by the program director once a year for the entire program. This form takes about 20 minutes to complete.

(5) **VHA Administrative Data**. VHA administrative data will be used to track MHICM process and outcomes using inpatient and outpatient service utilization data available from the Patient Treatment File and the Outpatient Care File in the Austin Data Processing Center.

c. **Mental Health Strategic Healthcare Group (MHSHG) Actions**. The MHSHG will:

(1) Assess, deploy, evaluate, and disseminate quality and cost efficient best practices by utilizing NEPEC, Management Science, and Allocation Resource Center data and expertise.

(2) Oversee effectiveness of MHICM program, monitoring, training, and evaluation by convening a broad based panel of experts to assess clinical and deployment outcomes and to determine future actions.

(a) The expert panel will consist of a NEPEC-based Chair (non-voting), five field members including a Chief Financial Officer (CFO), and three NEPEC and/or VHA Headquarters members. The panel will meet as needed but at least quarterly.

(b) The expert panel will provide a regular biannual summary report of its findings, conclusions and recommendations to the Policy Board.

(c) The expert panel will be responsible for preparing an annual cost and benefit analysis for the Policy Board.

(d) The expert panel will oversee, account, and provide a progress report to the Policy Board at appropriate times, but no less than annually, on the shift of resources to offset the resource needs of the MHICM program.

d. **NEPEC Actions.** NEPEC will:

(1) Provide direct oversight to all MHICM programs to ensure that standards are met through periodic site visits to treatment teams, regular national meetings of team leaders, conference calls, consultation, and national training programs. Programs systematically not meeting standards may be decertified from using the MHICM DSS Identifiers.

(2) Make additional efforts to integrate this data collection into standard VA computerized data systems, to provide sites with spreadsheet summaries of national and site-by-site program results on a regular basis, and to provide clinicians with client-specific output for clinical review.

(3) Be responsible for:

(a) Producing periodic reports on the structure, process, and outcomes of MHICM services for training programs in evaluation and clinical procedures.

(b) Working with the expert panel and its CFO (see subpar. 4c(2)) in the development of an effective costing system, such as activity-based costing, to account the MHICM program.

(c) Facilitating ongoing communication and linkage among programs across the country.

(d) Generating reports on VISN-level population-based needs assessments.

(e) Informing VISN and VA facility-level leadership where standards are problematic and recommending actions to strengthen the MHICM teams.

e. **Network Action**. Each Network will be responsible for:

(1) Addressing population-based needs for MHICM services;

(2) Establishing strategies to provide their severely mentally ill veterans within the described target population (see subpar. 2e(1)) access to MHICM services sufficient to meet the need, and

(3) Supporting recommendations by NEPEC to maintain MHICM standards.

5. REFERENCES: VHA Program Guide 1103.3, June 3, 1999, pages 9-11, 47. ***NOTE:*** *See <http://vaww.mentalhealth.med.va.gov/MHICMRef.htm> on VHA intranet for current clinical references.*

6. FOLLOW-UP RESPONSIBILITY: The Chief Consultant, Mental Health Strategic Healthcare Group (116) is responsible for the contents of this Directive.

7. RESCISIONS. None. This VHA Directive expires the last working day of September 2005.

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Under Secretary for Health

Attachments

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ATTACHMENT A

NEW DSS IDENTIFIER (STOPCODE) CHANGES FOR FISCAL YEAR 2000

(Abstracted from VHA Directive 2000-009)

Name/ Description	Stop code	CDR Account	Effective Date	Definition
TELEPHONE/MHICM	546	2780.00	10/1/99	Records patient consultation or psychiatric care, management, advice, and/or referral provided by telephone contact between patient or patient's next of kin and/or the person(s) with whom the patient has a meaningful relationship, and clinical, professional staff assigned to the special MHICM teams (see #552). Includes administrative and clinical services. **Provisions of 38 U.S.C. Section 7332 requires that records which reveal the identity, prognosis, diagnosis, or treatment of VA patients which relate to drug abuse, alcoholism or alcohol abuse, infection with HIV, or sickle cell anemia, are strictly confidential and may not be released or discussed unless there is written consent from the individual.
MENTAL HEALTH INTENSIVE CASE MANAGEMENT (MHICM)	552	5117.00	10/1/99	Only VA medical centers approved to participate in MHICM (previously IPCC) programs monitored by NEPEC may use this code. This records visits with patients and/or their families or caregivers by MHICM staff at all locations including VA outpatient or MHICM satellite clinics, MHICM storefronts, MHICM offices, or home visits. Includes clinical and administrative services provided MHICM patients by MHICM staff. Additional stop codes may not be taken for the same workload.
GENERAL TEAM CASE MANAGEMENT	564	2311.00	10/1/99	Records visits with patients and/or their families or caregivers by members of a case management team performing mental health community case management at all locations. Includes administrative and clinical services provided to patients by team members. NOT to be used for visits by MHICM teams (see #552) or for case management by individuals who use other stop codes.

ATTACHMENT B

MHICM TREATMENT POPULATION ESTIMATE FOR PLANNING PURPOSES

	Population Statistics			Discharged Psychiatric Inpatients (1)			Seriously Mentally Ill MH Outpatients			Psychiatric Complex VERA Class Patients (CMI)				Long-Term Inpatients (>1 yr LOS)		
VISN	Total Veterans	Eligible for VA Services	SC for MH Problem	Total Psychiatric Inpatients (1)	Percent Inpatients Eligible for MHICM (2)	Number Inpatients Eligible for MHICM (2)	Total SMI Out-patients (3)	Percent Out Pt's with 6 OP MH Visits (4)	Number Out Pt's with 6 OP MH Visits (4)	Schizophrenia and Dementia	Other Psycho-sis	PTSD	Total	Bed Psych.	Sections Med/ Surg	Total
1	1,500,892	358,094	32,435	5,204	30.9%	1,606	14,489	56.7%	8,220	926	324	435	1,685	94	20	114
2	697,421	194,415	12,296	2,355	41.8%	985	6,699	59.1%	3,961	440	171	200	811	18	0	18
3	1,595,593	335,211	29,644	4,716	45.9%	2,166	13,823	60.4%	8,348	1,250	377	505	2,132	196	23	219
4	1,819,870	497,402	27,526	5,047	35.7%	1,801	14,315	53.5%	7,660	930	295	465	1,690	51	9	60
5	857,564	168,218	9,715	3,405	29.3%	998	7,521	57.3%	4,310	502	112	365	979	62	13	75
6	1,251,189	360,885	22,017	4,936	30.1%	1,487	8,955	44.9%	4,023	501	149	319	969	64	1	65
7	1,367,528	399,439	25,458	4,888	29.1%	1,422	13,664	51.0%	6,967	790	175	569	1,534	67	43	110
8	1,634,357	482,839	43,852	5,083	18.3%	931	22,052	43.8%	9,658	440	247	506	1,193	0	0	0
9	1,060,416	367,654	21,666	4,246	21.9%	931	10,626	42.2%	4,481	391	136	169	696	65	0	65
10	1,151,473	318,983	16,861	3,993	32.9%	1,314	9,416	60.4%	5,691	720	196	372	1,288	4	0	4
11	1,651,186	427,356	18,906	4,240	24.2%	1,025	10,279	44.1%	4,528	849	188	284	1,321	193	25	218
12	1,362,314	319,235	15,530	4,372	39.8%	1,739	10,012	57.7%	5,773	606	368	410	1,384	70	0	70
13	707,005	210,110	11,153	2,533	40.9%	1,036	6,890	63.1%	4,346	317	173	190	680	1	0	1
14	516,075	153,798	6,675	1,711	41.2%	705	3,826	45.3%	1,732	194	102	140	436	0	0	0
15	1,071,604	329,293	15,963	4,152	27.3%	1,132	11,016	47.5%	5,229	540	277	342	1,159	7	0	7
16	1,887,301	651,983	39,737	6,995	30.9%	2,163	17,424	45.1%	7,865	877	256	534	1,667	1	0	1
17	1,026,699	321,378	17,795	3,727	37.4%	1,394	9,412	43.0%	4,046	669	314	404	1,387	169	1	170
18	842,132	276,151	15,687	2,833	18.0%	511	9,182	53.9%	4,945	152	118	274	544	0	0	0
19	731,842	215,445	11,835	2,490	34.1%	850	8,137	59.9%	4,876	317	195	337	849	0	0	0
20	1,191,422	342,926	21,245	4,444	32.7%	1,452	10,381	54.9%	5,702	301	227	416	944	0	0	0
21	1,418,772	338,504	19,259	3,292	38.2%	1,257	11,108	60.2%	6,689	518	263	524	1,305	0	0	0
22	1,841,007	418,847	20,114	3,627	29.5%	1,069	17,070	55.5%	9,478	713	463	364	1,540	1	0	1
TOTAL	27,183,662	7,488,166	455,369	88,289	31.7%	27,974	246,297	52.18%	128,528	12,943	5,126	8124	26,193	1,063	135	1,198
AVG	1,235,621	340,371	20,699	4,013	32.3%	1,272	11,195	52.70%	5,842	588	233	369	1,191	48	6	54
STD	397,725	113,743	9,168	1,171	7.4%	425	4,042	6.80%	1,982	268	93	121	420	63	11	70
CV	0.32	0.33	0.44	0.29	0.23	0.33	0.36	12.90%	0.34	0.46	0.40	0.33	0.35	1.30	1.85	1.28

(1) Discharged from Psychiatric bed sections, or other acute bed sections, or Domiciliary care with psychiatric primary diagnosis (excluding addictive disorders).

(2) Either greater than 30 bed days of care per year OR 3 or more admissions.

(3) Diagnosis of schizophrenia, major affective disorder, or bipolar disorder (ICD-9 codes 295.00-296.99).

(4) The official definition of an SMI patient in VA's capacity monitoring requires 6 or more OP visits per year.